STATE OF MICHIGAN

IN THE SUPREME COURT

Appeal from the Michigan Court of Appeals

ADVOCACY ORGANIZATION FOR PATIENTS & PROVIDERS, a non-profit Michigan corporation, et al.,

Plaintiffs-Appellants,

Docket No. 124639

v.

AUTO CLUB INSURANCE ASSOCIATION, a Michigan corporation, et al.,

Defendants-Appellees.

/

AMICUS CURIAE BRIEF OF THE MICHIGAN CATASTROPHIC CLAIMS ASSOCIATION IN SUPPORT OF DEFENDANTS-APPELLEES

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STATEMENT OF BASIS OF JURISDICTION

The jurisdictional summary set forth in Defendants-Appellees' Brief on Appeal is complete and correct.

COUNTER-STATEMENT OF QUESTION INVOLVED

I. DID THE COURT OF APPEALS PROPERLY AFFIRM THE CIRCUIT COURT'S ORDER GRANTING SUMMARY DISPOSITION TO DEFENDANTS AND DENYING PLAINTIFFS' MOTION FOR PARTIAL SUMMARY DISPOSITION, WHERE THE COURT OF APPEALS DECISION:

A. HOLDING THAT DEFENDANTS ARE PERMITTED TO EVALUATE MEDICAL BILLS SUBMITTED TO THEM FOR PAYMENT UNDER THE NO-FAULT ACT FOR REASONABLENESS; AND

B. REJECTING PLAINTIFFS' ARGUMENT THAT A "CUSTOMARY" CHARGE IS "REASONABLE" AS A MATTER OF LAW AND MUST BE PAID BY DEFENDANTS WITHOUT FURTHER REVIEW;

IS CONSISTENT WITH THE STATUTES AT ISSUE, GOVERNING CASE LAW, AND THE POLICY BEHIND THE NO-FAULT LEGISLATION?

The Circuit Court would answer:	Yes
The Court of Appeals would answer:	Yes
Defendants-Appellees would answer:	Yes
Amicus Curiae the MCCA would answer:	Yes
Plaintiffs-Appellants would answer:	No
This Court should answer:	Yes

THE INTEREST OF *AMICUS CURIAE* THE MCCA

The MCCA is a statutorily created organization of all insurers engaged in writing No-Fault insurance in Michigan. The MCCA is required to reimburse member companies for the amount of personal protection ("PIP") losses they incur in excess of $350,000 (i.e., "catastrophic claims") under No-Fault policies issued in the State. To fund its statutory indemnification obligations, the MCCA assesses premiums on member companies in relation to the number of No-Fault policies each member writes in Michigan. In many cases, the insurers then pass these assessments along to their Michigan policyholders.

As a result, this Court's ruling on the Court of Appeals decision regarding insurers' ability to independently review the medical bills submitted to them for payment to determine whether they are reasonable will have a substantial and wide-ranging impact on the MCCA and, through the MCCA's funding mechanism, on the insurance industry and ultimately, every person who buys No-Fault coverage in this State. If an insurer is statutorily required to pay medical bills it would have otherwise deemed unreasonable and these costs push the total amount of the PIP claim above $350,000, the MCCA must reimburse the insurer for the remainder of the claim above $350,000 that it is required to pay under No-Fault, without limitation. Because the MCCA is currently obligated to reimburse the insurer for all of the benefits it must pay in excess of $350,000 for a particular claim, and Michigan requires the payment by the insurer of medical benefits for life, the increase in costs of medical bills translates directly into increased payments that must be reimbursed by the MCCA. Thus, the MCCA has a direct interest in this matter.

COUNTER-STATEMENT OF FACTS AND PROCEEDINGS

The MCCA agrees with the Statement of Facts and Proceedings set forth in Defendants-Appellees' Brief on Appeal. However, the MCCA also provides the following facts regarding the creation and operation of the MCCA.

The MCCA was created by the Michigan Legislature in 1978 when it added Section 3104 to the automobile No-Fault statutes.[1] MCL 500.3104. The MCCA is a private, unincorporated, non-profit association. Every insurer engaged in writing No-Fault insurance for vehicles registered in Michigan must be a member of the MCCA as a condition of its authority to write No-Fault insurance in the State. MCL 500.3104(1). The MCCA indemnifies insurers for their ultimate losses in excess of a set amount which the members sustain in PIP benefits. That amount was originally set at $250,000 and increases yearly. The current level, which applies to policies issued or renewed during the period July 1, 2004 to June 30, 2005, is $350,000. MCL 500.3104(2). "Ultimate loss" is defined as "the actual loss amounts which a member is obligated to pay and that are paid or payable by the member". MCL 500.3104(25)(c). This includes medical bills and other benefits provided for under the No-Fault Act. In other words, once the insurer has paid $350,000 in benefits on a particular claim, it is deemed "catastrophic", and the MCCA then must reimburse the insurer for 100% of the benefits it is required to pay over and above the $350,000, including all benefits payable in the future. The MCCA is legally required to provide to its members, and the members are required to accept from the MCCA, this reimbursement. That is, members are prohibited from reinsuring these risks with private reinsurers or self-insuring against these risks.

[1] The Michigan Automobile No-Fault Insurance Act is found at MCL 500.3101 *et seq.*, and is referred to herein as the "No-Fault Act" or "the Act".

The MCCA was created by the Legislature in response to concerns that Michigan's No-Fault provision for unlimited, lifetime PIP benefits "placed too great a burden on insurers, particularly small insurers, in the event of 'catastrophic' injury claims" and caused a risk of insolvency, particularly of smaller insurers. *In re Certified Question: Preferred Risk Mutual Ins Co v Michigan Catastrophic Claims Ass'n*, 433 Mich 710, 714; 449 NW2d 660 (1989); see also *League General Ins Co v Michigan Catastrophic Claims Ass'n*, 435 Mich 338, 340; 458 NW2d 632 (1990) ("the cost of covering an insured's catastrophic losses...could be overwhelming to an individual insurance carrier"). In addition, the MCCA was created to spread the costs of catastrophic claims throughout the automobile insurance industry and increase the statistical basis for predicting the overall costs of such claims. *In re Certified Question,* 433 Mich at 714, citing House Legislative Analysis, SB 306, March 13, 1978.

The MCCA is also required to assess premiums on its members to fund its reimbursement obligations and operating expenses. MCL 500.3104(7)(d). The premium consists of two components. The first is an amount, known as the pure premium, reflecting the charge to cover the MCCA's expected losses and expenses during the assessment period. The second component is an adjustment to account for excess or deficient assessments from prior periods. *Id.* This second number is made necessary by the fact that calculating the pure premium requires the MCCA to estimate, in advance, the costs of indemnifying its members for claims it projects will be reported and incurred during the assessment period. It is therefore expected that the MCCA will adjust its actuarial assessments as claims develop over time, resulting in the modification of future cost projections for prior periods. Such adjustments lead to a recalculation, annually, of the estimated surplus or deficiency in the MCCA reserves. The statute provides for the MCCA

to make adjustments in the assessments for excess or deficient premiums from previous periods. *Id.*

The statute goes on to state that, "[p]remiums charged members by the association shall be recognized in the rate-making procedures for insurance rates in the same manner that expenses and premium taxes are recognized." MCL 500.3104(22). Thus, like other expenses, MCCA assessments may be reflected, in whole or in part, in the rates and premiums charged by insurers to Michigan No-Fault policyholders. As a result, any increase in the MCCA's claim costs increases the assessments charged by the MCCA to its members, which may then increase the premiums charged to policyholders.

INTRODUCTION

This case is about whether healthcare providers have the right to unilaterally determine what is a "reasonable" charge for their services, which charges must be paid by the insurer under the No-Fault Act, or whether insurers are entitled to independently review the charges submitted to them for reasonableness, with the ultimate decisionmaker being, where necessary, a judge or jury. The statutory language, case law, and policy behind the No-Fault legislation dictate that the answer to the former question be "no", and the answer to the latter, "yes". The No-Fault Act was and is concerned with the rising costs of both insurance premiums and healthcare. To allow providers carte blanche to state which of their fees must be paid would undermine these goals and result in increased costs to all concerned -- all, that is, except the providers.

ARGUMENT

I. THE STANDARD OF REVIEW

The MCCA agrees with the standard of review set forth by the parties. This appeal involves a matter of statutory interpretation and the review of a grant and denial of a motion for summary disposition, both of which are reviewed by this Court *de novo*. *See, e.g., Robertson* v

DaimlerChrysler Corp, 465 Mich 732, 739; 641 NW2d 567 (2002); *Nat'l Wildlife Fed'n v Cleveland Cliffs Iron Co*, ___ Mich ___; 684 NW2d 800 (2004).

II. THE COURT OF APPEALS DECISION IS CONSISTENT WITH THE LANGUAGE OF THE STATUTES AT ISSUE, WHEREAS A REVERSAL OF THE DECISION AND THE ADOPTION OF THE PLAINTIFFS' POSITION WOULD BE INCONSISTENT WITH THE STATUTORY LANGUAGE.

This case involves the interpretation of two portions of the No-Fault Act, specifically, sections 3107 and 3157, which govern payable PIP benefits. Section 3107 states that PIP benefits are payable for, *inter alia*, "all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation." MCL 500.3107(1)(a). A separate section, 3157, states:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

MCL 500.3157 (emphasis added).

Plaintiffs consistently argued in this case that the only limitation placed on a health care charge submitted for payment under the No-Fault Act is that it not exceed the amount customarily charged by the provider in cases involving uninsured patients.[2] Thus, they argue, a

[2] The MCCA acknowledges that the Plaintiffs are now focusing almost exclusively on the propriety of one particular method of medical bill review it claims Defendants have used, as opposed to the propriety of invoice review as a whole, which was the focus of Plaintiffs' claim in the Circuit Court and the Court of Appeals. However, because the holding of the Court of Appeals decision before this Court for review is that 1) insurers are permitted to independently review medical bills to determine whether a charge is "reasonable"; and 2) a "customary" charge is not necessarily "reasonable"; the MCCA addresses these issues in this brief, as opposed to the question of one specific method of review, which is discussed at length in Defendants-Appellees' Brief.

charge equivalent to that customarily charged to self-pay patients is, as a matter of law, reasonable and must be paid by the insurer without further review or question as to its reasonability.

One of the principal flaws in Plaintiffs' argument is that it ignores the simple fact that, had the Legislature wanted this to be the sole, singular limitation on a healthcare charge submitted for payment under No-Fault, it could have easily said so, by stating, for example, "a charge that does not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance is deemed reasonable for purposes of this Act", or the like. Or, even more simply, remove the requirement that a charge be "reasonable" altogether, and instead state only that those charges that are the same as that charged to uninsured patients must be paid by the insurer, since, according to Plaintiffs, "reasonable" and "customary" are one and the same thing. But, significantly, the Legislature did not do so.

Plaintiffs' argument actually tries to turn what is a ceiling (the charge for a similar service to uninsured individuals, which a PIP charge "shall not *exceed")* into a floor (the amount the provider is guaranteed to receive). Again, if this is what the Legislature intended, it could have easily so provided, but it did not. As the Court of Appeals stated, "nowhere in [Section 3157] does the Legislature indicate that a 'customary' charge is *necessarily* a 'reasonable' charge that *must* be reimbursed in full by the insurer." *Advocacy Organization for Patients & Providers v Auto Club Ins Ass'n*, 257 Mich App 365, 376; 670 NW2d 569 (2003) (emphasis in original).

Plaintiffs make much of the fact that neither the Legislature nor the electorate has implemented No-Fault fee schedules, and accuse Defendants of attempting to make an end-run around the legislative process and achieve this goal by way of their use of medical review

agencies which use a variety of ways to determine whether they believe a charge is reasonable. To the contrary, it is *Plaintiffs* that are trying to short-circuit the process and set fee schedules -- namely, the fees that they themselves set as their charges to the uninsured.

The simple fact is, unless and until the Legislature specifically directs to the contrary, the final arbiter of whether a fee is reasonable is a judge or jury. Do the providers want more certainty as to what they must be paid? Of course. Do the insurers want more certainty regarding what they will be required to pay? Of course. But neither side can make these determinations unilaterally. A provider can submit a charge that it believes is "reasonable"; an insurer can then pay the provider an amount which it believes is "reasonable"; and if the provider disagrees with the amount it has been paid, it can bring a claim against the insurer and ultimately, the trier of fact will determine the amount that is "reasonable", which the insurer will then be required to pay. Defendants' use of medical review agencies to help them determine the amounts they should pay providers does not run afoul of the No-Fault Act, as such agencies are not the final determinant of what is reasonable. However, a provider's being able to make a charge "reasonable" as a matter of law simply by charging that same amount, however absurd, to his, her, or its few uninsured patients (who, in all likelihood, will never pay the actual amount charged), is directly contrary to the language and spirit of the No-Fault Act.

As the Court of Appeals correctly stated, "the Legislature has not defined what is 'reasonable' in this context, and, consequently, insurers must determine in each instance whether a charge is reasonable in light of the service or product provided. . . . Either way, the trier of fact will ultimately determine whether a charge is reasonable." 257 Mich App at 379. The Sixth Circuit Court of Appeals made virtually the same statement in its opinion in this case. *Advocacy Organization for Patients & Providers v Auto Club Ins Ass'n*, 176 F3d 315, 320 (CA 6), *cert*

denied, 528 US 871 (1999) ("these statutory provisions leave open the questions of what a 'reasonable charge' is, who decides what is 'reasonable', and what criteria may be used to determine what is 'reasonable'").

III. THE COURT OF APPEALS DECISION IS CONSISTENT WITH MICHIGAN CASE LAW, WHEREAS A REVERSAL OF THE DECISION AND THE ADOPTION OF THE PLAINTIFFS' POSITION WOULD BE INCONSISTENT WITH WELL ESTABLISHED JUDICIAL PRECEDENT.

It is not surprising, given the language of the Act, that it has been held that "customary" and "reasonable" are two different things, and a fee must be both in order to be payable under the No-Fault Act. The Court of Appeals stated in *Hofman v Auto Club Ins Ass'n*, 211 Mich App 55, 114; 535 NW2d 529 (1995) that "*[i]n addition to* the 'customary charge' limitation discussed above, §§ 3107 and 3157 *also* impose a statutory qualification of reasonableness. . . ." (emphasis added). *See also*, *McGill v Automobile Ass'n*, 207 Mich App 402, 406; 526 NW2d 12 (1994) ("When read *in harmony*, §§ 3107 and 3157 clearly indicate that an insurance carrier need pay no more than a reasonable charge and that a health care provider can charge no more than that") (emphasis added). Thus, Plaintiffs' argument that "customary" equals "reasonable" is directly contrary not only to the statutory language, but to the case law as well.

Indeed, the courts have required insurers to do precisely that for which they are now being criticized by Plaintiffs, and which Plaintiffs seek to prohibit, namely, review the medical bills submitted to them for reasonableness. Over twenty years ago, the Court of Appeals stated, "it is clear that the Legislature did not intend for no-fault insurers to pay all claims submitted without reviewing the claims for lack of coverage, excessiveness, or fraud." *Lewis v Aetna Casualty & Surety Co*, 109 Mich App 136, 139; 311 NW2d 317 (1981). The court reiterated this in 1994 in *McGill*, 207 Mich App at 408, quoting *Lewis* verbatim and then again one year later in *LaMothe v Auto Club Ins Ass'n*, 214 Mich App 577, 582; 543 NW2d 42 (1995), *lv den,* 453

Mich 930 (1996). In fact, the *LaMothe* court made it clear that such a review was not only *permitted* under the law, but *required:*

> [T]his scrutiny by the insurance company would be compelled even if the contract itself did not provide for it because the statute controlling these contracts for automobile insurance requires it. Under the Michigan No-Fault automobile insurance act. . . insurers are responsible for 'all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.'. . . Furthermore, in the same statute, the Legislature has decreed that a health care provider cannot lawfully charge more than a reasonable amount for these products, services and accommodations. . . . Thus, not only should an insurer audit and challenge the reasonableness of bills submitted by health care providers, but the providers should expect no less.

214 Mich App at 582, n 3 (cites omitted). And the Court of Appeals recently once again reinforced the insurer's duty to review the bills provided to it in *Spect Imaging, Inc v Allstate Ins Co*, 246 Mich App 568, 577; 633 NW2d 461 (2001) (again stating, "it is clear that the Legislature did not intend for no-fault insurers to pay all claims submitted without reviewing the claims for lack of coverage, excessiveness, or fraud.").

Yet and still, Plaintiffs have challenged the ability of insurers to independently review the medical bills that Plaintiffs submit for payment. Under Plaintiffs' theory, all the No-Fault Act and the cases cited above require – nay, *allow* – the insurer to do is confirm that the amounts charged are not higher than those charged by the provider to uninsured individuals for similar services, and, if so, the inquiry should be at an end. Clearly, this is not the intent of either the No-Fault Act or *Lewis* and its progeny. As the Court of Appeals in this case correctly noted, "such an interpretation would require insurance companies to accept health care providers' unilateral decisions regarding what constitutes reasonable medical expenses, effectively eliminating insurance companies' cost-policing function as contemplated by the no-fault act". 257 Mich App at 378.

IV. THE COURT OF APPEALS DECISION IS CONSISTENT WITH THE GOALS OF, AND THEORY BEHIND, THE MICHIGAN NO-FAULT SYSTEM, WHEREAS A REVERSAL OF THE DECISION AND THE ADOPTION OF THE PLAINTIFFS' POSITION WOULD FLY IN THE FACE OF THE NO-FAULT LEGISLATION AND INCREASE COSTS TO INSURERS AND POLICYHOLDERS.

Perhaps most significantly, the position advocated by Plaintiffs is entirely inconsistent with the theory behind the No-Fault legislation and, if accepted by this Court, would result in precisely the opposite of that which the Act seeks to achieve, specifically, *increased* costs to insurers and consumers, and the unchecked ability of providers to set prices.

Central to the No-Fault statutory structure is the element of compromise. As this Court recently noted in *Kreiner v Fischer*, Nos. 124120 & 124757, ____ Mich ___; 683 NW2d 611 (July 23, 2004), the Act had a "compromise rationale". The "compromise at the heart of the No-Fault Act" is that, in many cases, a driver gives up the right to a tort claim in exchange for guaranteed payment of benefits, including medical bills, regardless of his or her fault in the accident. *Id.* Likewise, healthcare providers must also compromise. In exchange for the payment of benefits, without limitation in time or a maximum aggregate amount, the charges must be reasonable, and the determination of what is reasonable is not left to the providers.

Moreover, a primary goal of Michigan's No-Fault system is cost containment. This Court noted in *Shavers v Attorney General*, 402 Mich 554, 581; 267 NW2d 72 (1978) that the No-Fault Act was constitutional "in its general thrust", but at the time, required mechanisms "for assuring that compulsory no-fault insurance is available to Michigan motorists at fair and equitable rates". The Court directed the Legislature to take necessary action to ensure such availability, to which the Legislature responded with the passage of MCL 500.2100, *et seq*. This Court and the Legislature clearly were, and are, concerned with keeping the costs of the mandatory No-Fault insurance down. *See also, e.g., Davey v Detroit Auto Inter-Ins Exchange*,

414 Mich 1, 17; 322 NW2d 541 (1982)(while one objective of no-fault was providing an "assured, adequate and prompt recovery for certain economic losses arising from motor vehicle accidents. . . we have also recognized a complementary legislative objective which is the containment of the premium costs of no-fault insurance"); *Tebo v Havlik*, 418 Mich 350, 367; 343 NW2d 181 (1984) ("the Legislature made a trade-off. Those who were required to participate in the no-fault scheme gave up the possibility of redundant recoveries, but they were intended to receive the benefit of lower insurance rates"); *Moore v Travelers Ins Co*, 475 F Supp 891, 895 (ED Mich, 1979) ("the aim of no-fault was to lower insurance premiums"); *Stevenson v Reese*, 239 Mich App 513, 519; 609 NW2d 195 (2000) ("a primary goal of the no-fault act is to provide an efficient, affordable system of automobile insurance").

A concomitant goal of No-Fault is to keep healthcare costs down. "The no-fault act was as concerned with the rising cost of healthcare as it was with providing an efficient system of automobile insurance." *Dean v Auto Club Ins Ass'n*, 139 Mich App 266, 274; 362 NW2d 247 (1984). Indeed, the *Dean* court noted that the language of Section 3107, providing that insurers are required to pay only those charges which are reasonable, shows the Legislature's intent to "place a check on health care providers who have 'no incentive to keep the doctor bill at a minimum.'" *Id.* at 273. *Dean* concluded by stating that the reasonableness requirement "represents the policy of this state that the existence of no-fault insurance *shall not* increase the cost of health care." *Id.* at 274 (emphasis in original). *See also, e.g., McGill*, 207 Mich App at 408 (same); *Gooden v Transamerica Ins Corp*, 166 Mich App 793, 800; 420 NW2d 877 (1988) ("the basic goal of the no-fault insurance system is to provide individuals injured in motor vehicle accidents assured, adequate and prompt reparation for certain economic losses *at the lowest cost to the individual and the system*") (emphasis added); *Dolson v Secretary of State*, 83

Mich App 596, 599; 269 NW2d 239 (1978) (same); *Spencer v Citizens Ins Co*, 239 Mich App 291, 300; 608 NW2d 113 (2000) (same).

Both of these goals would be thwarted if the Court of Appeals decision is reversed.

1. Acceptance of Plaintiffs' Position Would Increase Health Care Costs.

It cannot be seriously debated that if Plaintiffs' argument were accepted by this Court and insurers were required to pay all charges so long as they did not exceed the charges for similar services to uninsured individuals, health care charges would rise significantly. Plaintiffs have not disputed the fact that the percentage of patients who have no private health care insurance or coverage through governmental programs such as Medicare or Medicaid is small. And Plaintiffs stand firm that it is not the amount they *accept* as payment from such individuals that is relevant, but rather, simply the amount *charged.* So according to Plaintiffs, whatever amount they decide to charge this small percentage of patients, who lack any bargaining power whatsoever to negotiate rates, and who in all likelihood will pay a fraction, if any, of the amount charged, is the "customary" charge that No-Fault insurers are obligated to pay. This argument defies logic and is contrary to the No-Fault mandate that a charge be "reasonable".

Providers have "no incentive to keep the doctor bill at a minimum" for uninsured individuals and the data shows that this has resulted in increased charges. Dr. Gerard Anderson, Director of the Johns Hopkins Center for Hospital Finance and Management recently testified before a U.S. House Subcommittee on the issue of hospital charges to uninsured individuals. The doctor testified that his research reveals that hospitals set charges at *two to four times* more than what they expect to collect from insurers and managed care plans. *A Review of Hospital Billing and Collection Practices, Before the House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce*, 108th Congress (2004) (witness testimony of Dr. Gerard Anderson), attached as Exhibit A, p. 7. Similarly, Glenn Melnick, Director, Center

for Health Financing, Policy and Management, University of Southern California, testified earlier this year before a different House Subcommittee on the same subject. He noted that the uninsured "face higher fees for the same procedure than the insured since they do not benefit from the bargaining clout of an insurance company" and presented data about the different amounts paid by the uninsured versus the insured for the same procedure. *Hearing on the Uninsured, Before the House Subcommittee on Health, Committee on Ways and Means*, 108th Congress (2004) (statement and testimony of Glenn Melnick, Ph.D), attached as Exhibit B, p. 2.[3] Although this data relates to hospitals, it shows the trend in the industry, and there is no reason to believe that doctors or other treaters are acting differently.

Thus, if the providers treating individuals covered by No-Fault PIP benefits follow this same pattern and practice, their charges to the uninsured will be two to four times more than what they would accept in payment from a health insurance company, yet the automobile insurance company would be required to pay the full amount. And keep in mind that this has to be multiplied on a large scale – No-Fault insurers are required to pay the reasonable charges for all necessary services during the lifetime of the insured, without a total dollar cap. There will be thousands upon thousands of charges submitted by providers for treatment due to automobile accidents, whether the accident was decades ago or yesterday, not to mention those that will occur in the future. And under Plaintiffs' argument, *not one of these* will be subject to any limitation whatsoever other than whether it is the same charge as that made to the uninsured (which nobody does or could check for reasonableness). Period -- no further analysis or review necessary, or permitted, by the insurer.

[3] It is notable that Plaintiffs do not discuss how much higher their charges are in cases not involving insurance than in cases where the patient is insured. One must assume the difference is substantial.

2. Acceptance of Plaintiffs' Position Would Increase Insurance Premiums.

It is a virtual certainty that, should insurers be prohibited from independently reviewing invoices for reasonableness and be legally required to pay those charges that are equivalent to the charges imposed in cases not involving insurance, the ultimate result will be an increase in the cost to consumers of insurance premiums. The MCCA is interested in this case because whenever the PIP benefits payable in a case exceed $350,000, the MCCA is obligated to reimburse the insurer for all statutorily provided payments made in excess of that amount. When medical bills increase, more cases meet the PIP threshold – not just new cases involving significant injuries, but also cases where the injuries occurred years ago.

In order to fund its reimbursement obligations, the MCCA, a nonprofit association, imposes charges on its members. As discussed above, these charges consist of two elements -- the pure premium, reflecting the charge to cover the MCCA's expected losses and expenses during the assessment period, and an adjustment to account for excess or deficient assessments from prior periods. MCL 500.3104(7)(d). To the extent medical bills increase significantly, both components of the assessment charge will increase. The expected losses for the assessment period will be higher, resulting in increased pure premiums, and an adjustment will likely be necessary due to deficient reserves, because the MCCA's actuarial assessments were and are based on a system in which charges must be "reasonable", not just "customary", and where insurers are entitled to independently review charges. Should this change, actuarial assessments will have to change as well.

The statute creating and governing the MCCA also provides that the premiums charged by the MCCA to member associations "shall be recognized in the rate-making procedures for insurance rates in the same manner that expenses and premium taxes are recognized." MCL 500.3104(22). Thus, the MCCA assessments, in whole or in part, may be, and usually are,

passed along in the rates charged by insurers to their policyholders. Indeed, insurers cannot survive without being able to pass along their increased costs of doing business. Plaintiffs' argument, if accepted, will have a domino effect – it will cause increased medical costs, which will result in more claims being submitted to the MCCA, which will increase the assessments the MCCA is required to impose on its members, which will then increase the cost of No-Fault insurance premiums for the consumer. (Even in cases where the MCCA is not involved, *i.e.*, those which do not rise to the level of catastrophic, the insurers will bear increased costs, which also affect premium levels). Not surprisingly, the only group to benefit from such an outcome is the providers. Such a result is inconsistent with the statutory language, case law, and public policy behind the No-Fault Act and should not be countenanced.

In the existing system, providers submit bills, the insurance companies review the bills and determine what they believe are reasonable charges and make payment of same, and the provider reserves the right to challenge those determinations in a court of law or other forum. While this procedure may be less convenient or more cumbersome than a system where there is a "set" fee, whether it is a fee schedule or its equivalent (here urged to be the amount charged to uninsured individuals), unless and until the Legislature amends the No-Fault Act, it is the only system compatible with the purposes, policies and provisions of the Act.

RELIEF REQUESTED

The Michigan Catastrophic Claims Association joins the request of the Defendants-Appellees that the decision of the Court of Appeals be affirmed.

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Dated: September 8, 2004

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Witness Testimony

Dr. Gerard Anderson
Professor, Department of Health Policy & Management and International Health, Bloomberg School of Public Health
Johns Hopkins School of Medicine

A Review of Hospital Billing and Collection Practices
Subcommittee on Oversight and Investigations
June 24, 2004
1:30 PM

Mr. Chairman, members of the Committee; my name is Dr. Gerard Anderson. I have been working on hospital payment issues for many years. Between 1978 and 1983, I worked in the Office of the Secretary in the US Department of Health and Human Services. In 1983, I was one of the primary architects of the Medicare Prospective Payment legislation. Following passage of the Medicare Prospective Payment legislation, I joined the faculty at Johns Hopkins where I have been for the past 21 years. At Johns Hopkins, I direct the Johns Hopkins Center for Hospital Finance and Management - the only academically based research center focusing exclusively on hospitals. I am also a professor of Health Policy and Management and professor of International Health in the Bloomberg School of Public Health and Professor of Medicine in the School of Medicine at Johns Hopkins University.

I would like to begin my testimony by highlighting several milestones in hospital payment policy. Because of the evolution of hospital payment policy, self pay patients are currently being charged 2 to 4 times what people with health insurance coverage pay for hospital services. These are not market rates and need to be lower. After reviewing the milestones, I will then make a series of specific suggestions to the committee that will make the current hospital payment system more equitable to the self pay patients. My preferred option is that hospitals be limited to what Medicare pays plus 25 percent.

Critical Milestones That Have Led To Market Failure in Hospital Payment

One hundred years ago most hospital care was either free or very inexpensive. In 1900, hospitals ~~were institutions that~~ could provide little clinical benefit for most illnesses and were primarily places for housing the poor and insane who were sick. Hospitals were primarily philanthropic organizations. They were established primarily in poor urban areas.

Beginning in the 1920s, the ability of hospitals to improve the health status of patients increased dramatically. For the first time, rich and poor Americans sought out hospital care when they became seriously ill. Anesthesia expanded access to surgery and antibiotics made it easier to treat infections.

Physicians had a wider range of services to provide to hospitalized patients. New drugs and new equipment became available and better and more highly trained personnel were required to provide these services. The cost of providing hospital care began to accelerate. In order to recover these higher costs, hospitals began to charge patients for services. Hospitals developed a charge master file. Initially there were only a few items on the list. It listed specific charges for each service the hospital provided. A hospital day had one charge, an hour in the operating room had another charge, and x-ray had a third charge, etc. As the number of services the hospital offered increased, so did the length of the charge master file. There are now over 10,000 items on most hospital charge master files.

Before 1929, there was no health insurance and patients paid the hospital directly. In 1929, Baylor Hospital in Dallas, Texas began a program selling health insurance to school teachers in the Dallas County School district. Baylor created this health insurance system because many of its patients were having difficulty paying hospital bills. It became the prototype Blue Cross Plan. As the depression worsened in the 1930s, the ability of people to pay their hospital bills also worsened. Blue Cross and other types of insurance programs proliferated. These insurers paid charges based upon the charge master file.

During this period, the charges were based on the cost of providing care plus a small allowance for reserves. The markup over costs was typically less than 10%.

Private health insurance received a major boost during World War II when Congress made health insurance tax exempt. After World War II,

private insurers continued to pay the charges that hospitals had established. Over time, the ability of hospitals ~~hospitals ability~~ to improve the health status of their patient~~'~~s increased, the kinds of services provided by hospitals increased and the costs of hospital care began increasing at 2 to 3 times the rate of inflation~~—~~. By 1960, the typical hospital had established a list of prices for approximately 5,000 separate items. There were no discounts; everyone paid the same rates. The rates that insured and self pay people paid were similar.

Hospitals set their prices for these 5,000 items on a few criteria~~.on.~~ The most important factor was costs. Charges were typically set at a given ~~a~~ markup over costs, usually 10 percent. The hospital would estimate how much it cost to deliver a service and then charge 10% more. The ability of hospitals to estimate cost for individual services, however, was extremely limited by cost accounting. No hospital really knew how much it costs to provide a particular service because cost accounting techniques were not sufficiently detailed.

~~for a very few services change may have been determined by market forces.~~ Market forces determined charges for only a few services. Child birth for example, was one service for which patients could engage in comparative shopping. Pregnant women had almost nine months advance warning that they would be admitted to the hospital and their families could therefore engage in comparative shopping. In theory, they ~~would~~ could compare differences in the out-of-pocket costs and the perceived quality between two hospital delivery rooms~~. and their perceived quality.~~ Thus, ~~Because of this,~~ hospitals kept delivery room charges at or below actual costs.

For most services, however, it was often impossible for consumers to engage in comparative shopping because either ~~for most services comparative shopping was not possible. Either~~ the admission was an emergency or their doctor had admitting privileges in only one hospital. For most admissions, they had no idea what services they would use during their hospital stay. They could not engage in comparative shopping if they did not know what services they were going to need. In addition, for most people, insurance paid the full bill and so patients had no financial incentive to engage in comparative shopping.

Medicare Becomes Involved

When the Medicare program was established in 1965, Congress decided that the Medicare program would pay hospital costs and not charges. This was the method of payment used primarily by

Blue Cross. Congress recognized that charges were greater than costs and that the Medicare program would be able to exert little control over charges. A very detailed hospital accounting form called the Medicare Cost Report, was created to determine Medicare's allowable costs.

In order to allocate costs between the Medicare program and other payors, the Medicare program required hospitals to collect uniform charge information. Uniform charges were necessary in order to allocate costs to the Medicare program. The Medicare Cost Report could determine allowable costs for the entire hospital, however, it needed a way to allocate these costs specifically to the Medicare program. Charges are used to allocate costs to the Medicare program. If, for example, 40% of the charges were attributed to the Medicare program, then the cost accounting system would allocate 40% of the costs to the Medicare program.

In order to prevent fraud and abuse, the Medicare program required hospitals to establish a uniform set of charges that would apply to everyone. Otherwise, the hospital could allocate charges in such a way that would result in more costs to the Medicare program.

Hospitals continued to have complete discretion on how they established their charges. The Medicare program did not interfere with how hospitals set charges for specific services. One hospital could charge $5 for an x-ray and another hospital $25 for the same x-ray. A number of studies conducted at the time showed wide variation in hospital charges.

People with insurance generally had little reason to scrutinize their bills because they had first dollar coverage. Insurance paid the full hospital bill. Also, patients did not know what services they would need and so they did not know what prices to compare. Insurance companies did little to negotiate with hospitals regarding hospital charges in the 1960s and the Medicare and Medicaid programs did not pay on the basis of charges.

In the 1970s, market forces still had a small impact on hospital charges. In reality, the hospital had virtual carte blanche to set the charges. The number of separate items that had a charge associated with them, doubled from 5 to 10,000 at the typical hospital, where it is today.

Two major changes occurred in the 1980s that had a major impact on hospital charges. First, Medicare created the Prospective Payment System which eliminated any need for using hospital charges to allocate hospital costs. Second, most insurers

began negotiating discounts off of charges or using some other mechanism to pay hospitals. As a result, any market forces that existed to limit what hospitals could charge were almost completely eliminated.

In 1983, the Medicare program moved away from paying costs and instituted the Prospective Payment System (DRGs). As the Medicare Prospective Payment System became operational, the need for the Medicare Cost Report and therefore the need for a uniform charge master file to allocate costs became less and less important. Today, because nearly all of the Medicare program uses some form of prospective payment, the requirement of a uniform charge master file by the Medicare program is virtually unnecessary.

Managed care plans began to negotiate with hospitals in the early 1980s. They wanted discounts off of charges in return for placing the hospital in their network. They successfully negotiated sizeable discounts with hospitals. As insurers began to compete with managed care plans in the mid 1980s, they also began to move away from paying full charges and started negotiating their own deals. Some insurers decided to pay on a per day basis, others decided to pay discounted charges, or a negotiated rate. Nearly all private insurers and managed care plans stopped using full charges as the basis of payment by 1990. They simply could not compete in the market place if they paid full charges.

Cost Shifting and Market Failure

As each segment of the market developed a different way to pay hospitals, this lead to a phenomenon known as "cost shifting". As the Medicare program instituted the Prospective Payment System (DRGs), the Medicare program began to limit the amount that Medicare would spend. Faced with constraints on Medicare (and soon thereafter Medicaid) spending, the hospitals began to engage in "cost shifting".

To do this the hospital industry increased prices to commercial insurers. Given that most commercial contracts were written to reimburse hospitals based on the hospital's own charges, it was relatively simple matter for hospitals to raise their prices. When commercial insurers tried to raise prices to the employers, however, employers began to examine alternatives. Employers slowly and then rapidly embraced managed care. Managed care expanded rapidly using their market power to negotiate discounts off of charges with hospitals. Soon commercial insurers asked for similar discounts. Private insurers continued to pay more

than Medicare however in most cases.

Without the federal government, state governments, private insurers, or managed care plans paying full charges, the regulatory and market constraints on hospital charges were virtually eliminated. By 1990, the only people paying full charges were the millions of Americans without insurance, a few international visitors and the few people with health savings accounts. These individuals had limited bargaining power and were asked to pay ever increasing prices. Effectively, there was market failure in this aspect of the hospital market.

Without any market constraints, charges began increasing much faster than costs. In the mid 1980s charges were typically 25% above costs. Without any market constraints, it is now common for charges to be two to four times higher than costs. Charges are also two to four times what most insurers pay. Most insurers, including Medicaid, Medicare, and private payors, pay costs plus/minus 15 percent. Over the past twenty years, the difference between what the hospital charges and what it costs to provide care has grown steadily in nearly all hospitals.

Hospitals have been able to increase charges because self pay individuals have limited bargaining power when they enter a hospital. ~~When an uninsured person enters a hospital they have limited bargaining power.~~ They first must find a team of physicians willing to treat them who also have privileges at that hospital. Then they must negotiate with the hospital. Often they wait until they are ill before they seek medical care. This further diminishes their bargaining power because it is now an emergency. Often the hospital wants prepayment. Because most self pay persons have limited resources and cannot make full payment in advance, this further diminishes their bargaining power.

Perhaps the most important constraint on their bargaining power, however, is that they do not know what services they will ultimately need. They do not know how long they will remain in the hospital, what x-rays or lab tests they will need, and therefore they cannot know in advance what services they will require and which of the 10,000 prices they should negotiate.

Costs, and What Insurers Pay in Pennsylvania

Using the most recent data available I compared what insurers pay and what hospitals charge in Pennsylvania. As noted earlier, charges vary considerably from hospital to hospital.

Pennsylvania collects data on what hospitals charge and what insurers pay in Pennsylvania for different illnesses (www.phc4.org). For example, I looked at the charges that Philadelphia area hospitals charged for medical management of a heart attack in 2002. The average charge was over $30,000. Most insurers paid less than $10,000.

Why Are Charges So Much Higher Than What Insurers Pay?

There are three main reasons why hospitals set charges 2-4 times what they expect to collect from insurers and managed care plans. The first is that Medicare outlier payments are partially based on charges. The second is that bad debt and charity care is typically calculated at full charges. The third is that some self pay patients actually pay full charges.

In the Medicare program, a small proportion of patients are much more expensive than the average patient. These are known as outlier patients. Medicare pays for these patients outside of the DRG system. Medicare continues to use charges as part of the formula used to determine outlier payments.

Recent investigations have shown certain hospital systems manipulating the payment system in inappropriate ways to over charge the Medicare program for outlier patients. One aspect of this fraud was the exceptionally high amounts these hospitals charged. Lowering the charges would diminish the over charges in the Medicare program for outlier payments and would reduce the level of fraud.

Second, hospitals routinely quantify the amount of bad debt and charity care they provide. This helps with fund raising and is used to meet charitable obligations. However, by valuing bad debt and charity care at full charges, these numbers vastly over estimate the amount of bad debt and charity care the hospital actually provides.

There are three groups that still pay charges. The first are people who have health savings accounts. Some of these individuals may be able to negotiate discounts although most pay full charges. It is extremely difficult for one person to negotiate with a hospital, especially in an emergency situation. The hospital holds all of the cards. Lowering the charges will benefit people with health savings accounts.

The second category is international visitors. These are typically affluent individuals who need a procedure that can be performed most

effectively in the United States. These individuals are willing to pay full charges, even at inflated prices.

There are compelling arguments to charge international visitors higher prices than Americans. Most can afford to pay and, in addition, they have not subsidized the hospital sector in the United States through tax payments and other public subsidies. On the other hand, in most other countries Americans are usually treated free of charges if they have an emergency. An American injured while traveling in Canada, Australia, France, etc would be treated free of charge or receive a very small bill. Although there is no data that I know of that would allow us to compare the cost of care provided to Americans traveling abroad to the cost of care provided to foreigners receiving care in the U.S., I expect it would be similar. In that case it seems unfair to charge foreign visitors so much more for a service when Americans receive care free of charge overseas.

Impact On The Uninsured

The third, and by far the largest group that is asked to pay full charges is the uninsured. There are 43 million Americans who are uninsured. The uninsured can theoretically negotiate with hospitals over charges, but they have little bargaining power. My review of hospital practices suggests that less than 1 in 20 uninsured patients actually negotiates a lower rate.

Many uninsured people are unable to pay full charges. In fact, most studies suggest that less than 1 in 10 uninsured people pay a portion of their charges and relatively few pay full charges. In fact, in most hospitals only 3 percent of total revenues comes from people who are uninsured. Self pay patients represent a very small proportion of hospital revenues.

The toll on the uninsured, however, can be substantial. There are numerous reports that show hospitals attempting to collect payments from the uninsured. The people who do not pay are sent to collection agencies and some are driven to bankruptcy. One study found that nearly half of all personal bankruptcies were related to medical bills (M.B. Jacoby, T.A. Sullivan, E. Warren, "Rethinking The Debates Over Health Care Financing: Evidence from the Bankruptcy Courts," NYU Law Review 76, May 2001: 375). Another survey (D. Gurewich, R. Seifert, J Pottas, The Consequences of Medical Debt: Evidence From Three Communities, The Access Project, February 2003) found that hospitals were routinely requiring up front payments, refusing to provide care, or encouraging uninsured patients to

seek new providers if they did not have health insurance. Many respondents found the terms the hospitals were offering were difficult to maintain given the hospitals' inflexible collection processes and their own financial situations.

Nearly all hospitals do this to some extent. For example, a series of stories in the Wall Street Journal examined the collection procedures at Yale-New Haven hospital. The Wall Street Journal found that in 2002, the Yale- New Haven hospital was lead plaintiff in 426 civil lawsuits, almost all of which concerned collections or foreclosure lawsuits against individuals, compared with 93 lawsuits at a similarly sized local hospital. Yale- New Haven Hospital also frequently engaged in aggressive collections measures, such as wage garnishment, seizure of bank accounts, and property liens. In 2001, the hospital filed 134 new property liens in New Haven, almost 20 times the number filed by the city's other hospital.

Benefits of Lower Charges

If charges were lowered there could be two beneficial outcomes. First and most important, fewer self pay individuals would declare bankruptcy. Second, more self pay patients would be able to pay their bills if the charges were more in line with prevailing rates.

Guiding Principles for Setting Rates

The question therefore becomes what is a reasonable rate for hospitals to charge self pay patients given that neither market forces or regulations constrain hospital charges.

I propose four guiding principles. First, the rate should not interfere with the market place. The rate that self pay individuals should pay should be greater than what insurers and managed care plans are currently paying hospitals. Second, the charges should not be substantially higher than what insurers and managed care plans are currently paying hospitals. Individuals with limited bargaining power should not be asked to pay exorbitantly high rates because they lack market power. Third, the rate should be transparent to patients. Patients should know the prices they will be asked to pay when they enter the hospital. Fourth, the system should be easy to administer and to monitor.

Two Payment Alternatives

I have two specific suggestions for the Congress to consider.

The first is to mandate that the maximum a patient can pay is the amount paid by Medicare plus 25%. I call this DRG+25%. The rationale for allowing hospitals to charge 25 percent more than Medicare is based on three factors. First, private pay insurers pay an average of 14 percent more than Medicare for a similar patient. I then add one percent for prompt payment. Finally, an additional amount (10%) is added because the amount paid by private insurers is an average and some commercial insurers pay more than the average. Adding the three factors together results in a proposed payment rate of DRG + 25%.

The advantages are that the DRG + 25% rate is easily monitored and adjusts for complexity of the patient. It would be continually updated by Medicare as Medicare updates the PPS rates. The disadvantage is that the rate is not market determined. In most markets, however, it would be above what insurers and managed care plans are paying.

A second option is to allow hospitals to charge the maximum they charge any insurer or managed care plan on a per day basis. The advantage is that it is market determined.

There are four disadvantages. First, it will require regulations and auditing to verify the rate is the maximum they charge any insurer or managed care plan. Second, in order to make the rate transparent, it will be necessary to keep the rate in place for an extended period of time, probably a year. This interferes with the market place. Third, it will require hospitals to tell all insurers and managed care plans who was the worst negotiator. This also interferes with the market place. Fourth, it requires all negotiations to be on a per day basis. Any other payment system would be too complicated. This interferes with the market place.

Balancing the pros and cons of both options, I recommend the DRG+25% option. It complies with all four principles- it is above what insurers are paying, it is a reasonable amount, it is transparent, and it is easy to monitor and verify.

Rate Is Too Low

Insurers may argue that they are entitled to more substantial discounts over self pay individuals for two reasons- prompt payment and volume discounts. The prompt payment argument has some validity. A two month delay in payment at a 6 percent interest rate is equivalent to a 1 percent savings. This is built into the DRG + 25% payment.

The volume discount argument is more complicated. In my opinion it has limited financial impact, especially on medical services. Most insurers and managed care plans do not guarantee a certain volume of patients and certainly they do not guarantee a certain case mix of patients. Instead, they agree to put the hospital on a preferred list of hospitals. The patient and the physician still make the final decision regarding which hospital to select. The choice, therefore is fundamentally different from a purchase in the manufacturing or retail sector where a large volume of goods or services is actually purchased.

The second part of the volume argument, however, is probably more important. The same medical services will be used if the patient is self pay or insured. The patient will use the same set of laboratory tests, spend the same time on the operating table, require the same nursing hours, etc. The medical services are what is most expensive in a hospital and this does not depend on the volume of patients that an insurer has.

Incentives to Purchase Health Insurance

Some individuals with high incomes choose to self insure. An important and difficult question is whether these individuals should be able to get the benefits from these lower rates.

One argument is that these individuals have voluntarily chosen to go without health insurance and they should pay a much higher rate if they get sick. A second argument is that these individuals should be given financial incentives to purchase health insurance and that lowering the hospital rates for them will only induce them to go without coverage.

Although there is merit in both arguments, the question is what is a fair rate for them to pay when they get sick? When they need hospitalization they should pay a rate that is somewhat higher than people with health insurance coverage pay. The DRG +25% criterion meets this objective. This group of people should not be asked to pay for the bad debts of other self pay patients any more than the insured population. And, if the rates were reasonable they would be more likely to pay.

Simplification of Payment System

The medical care system could be simplified if such a change were enacted. One major change would be the elimination of the Medicare Cost Report. A second simplification is that it would be easier to calculate any discounts that hospitals are offering to low income individuals.

The Medicare Cost Report was created in 1965 with the passage of the Medicare legislation and the decision by the Congress to pay costs. The Medicare cost report is now a document that is over 6 inches thick and requires many hours for hospitals to complete. However, with the passage of the Medicare Prospective Payment legislation in 1983 and subsequent adoption of additional Prospective Payment Systems for outpatient care etc., there is no longer a compelling reason for maintaining the Medicare Cost Report. Any information the Congress needs from hospitals to set hospital payment rates could be summarized in a few pages. The only relevant information is the profit of hospitals and some information used to calculate graduate medical education and disproportionate share payments.

Hospitals often give discounts to low income self pay patients. It is therefore key to understand what is the basis for the discount. A discount from full charges is not really a discount if it is still greater than what insurers and managed care plans would pay. A true discount would be below what public and private payors are expected to pay. If the payment system for self pay patients were simplified (DRG + 25%) then it would be easier for them to determine if they are really getting a discount and how much they were expected to pay. Currently the self pay person does not know the real extent of the discount or how much they will pay.

Summary

In summary, what should be done?

1. Both Congress and the hospital industry should recognize that hospital charges are not determined by market forces. The only people paying full charges are those with limited or no bargaining power.

2. The maximum that self pay individuals should have to pay for hospital services should be DRG rate plus 25%.

I would be happy to answer any questions.

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Witnesses

Douglas Holtz-Eakin, Ph.D., Director, Congressional Budget Office

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Panel:

Diane Rowland, Sc.D., Executive Director, Kaiser Commission on Medicaid
Uninsured

Len M. Nichols, Ph.D., Vice President, Center for Studying Health System

Glenn Melnick, Ph.D., Director, Center for Health Financing, Policy and Man
University of Southern California, School of Policy, Planning and Developme
Angeles, California

Greg Scandlen, Director, Center for Consumer Driven Health Care, Galen In

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House Committee on Ways and Means

Statement of Glenn Melnick, Ph.D., Director, Center for Health Financing, Policy and Management, University of Southern California, School of Policy, Planning and Development, Los Angeles, California

Testimony Before the Subcommittee on Health
of the House Committee on Ways and Means

March 09, 2004

Hospital Pricing and the Uninsured

I will first discuss powerful trends in hospital pricing that I am afraid will worsen the problem of the uninsured in America and stifle the market for HSAs. I will then present a set of recommendations designed to limit the negative effects of these trends.

Hospital pricing as currently practiced negatively impacts the uninsured

We have witnessed a very significant and rapid increase in hospital list prices over the past 8 years in the US.

Hospital Pricing Terminology and Practices

To better understand hospital pricing, some terminology is required. Hospitals have two sets of prices: list prices and net prices.

Hospital list prices (more commonly referred to as gross charges) are a standard set of prices established by hospitals each year (generally) for all their services. The list price is more or less equivalent to the "rack rate" that hotels display for their rooms. All patients are charged the same list price for the same service.

However, very few patients actually pay the list price (see Exhibit 1). Insurance companies and other third party payors generally have contracts with hospitals, either directly or indirectly through rented provider networks, which allow them to pay a discounted price that is significantly below the list price. Uninsured patients (referred to in most hospital accounting systems as self-pay) are charged the list price and then depending on the individual hospital's pricing policy, may be offered a discount. The actual amount a hospital receives from the patient will be based on this discounted price less any portion of the bill that turns out to be un-collectible.

Hospital pricing strategies are driven by a complex mix of differing payment schemes and contracting arrangements as well as market forces.

With the advent of selective contracting and the growth of managed care in the US, the practice of negotiating discounts with hospitals has become widespread. In this environment the gap between list and net prices has widened. Contracting, combined with market forces, largely drives hospital net prices. Consequently, most insurers, policymakers, and researchers have focused on net prices. However, there are a number of factors that have kept hospital list prices important in overall hospital pricing and which have contributed to the rapid run-up in list prices. These factors include:

- Not all third party payors have contracts with all providers (i.e., Some third parties pay list prices or charges).
- Many third party contracts include payment formulae where the discount is applied to list prices (or charges).
- Many third party contracts (including Medicare) have stop-loss provisions that pay on the basis of list prices (charges) above a certain threshold.
- In many cases the stop loss threshold is based on list prices (charges).
- Not all insured patients are covered by a third party at every hospital (e.g, for out-of-network use)
- Some patients have no insurance coverage (self-pay patients) and do not have access to negotiated discounted prices at any hospital

Since most hospitals can increase their net revenue (from private insurers, Medicare, and workers comp plans) by raising their list prices, there is a strong incentive to keep increasing list prices. Indeed, data show that list prices have increased rapidly and substantially in recent years.

The following data provide a picture of what has happened to hospital list prices in recent years:

- Hospitals have increased their list prices much faster than their costs have gone up and much faster than their net prices (see Exhibits 2 and 3 for California data and Exhibit 4 for national data).
- The difference between hospital list prices and costs varies substantially from state to state across the US (see Exhibit 5).
- The difference between hospital list prices and net prices varies substantially across hospitals within the same state (data can be obtained from the author)

An indirect and largely unintended effect of these trends is that they have created hardship for uninsured patients – the hospital prices they face are increasing more than for any other group.

Not only do the uninsured pay for all their care out-of-pocket, but they face higher fees for the same procedure than the insured since they do not benefit from the bargaining clout of an insurance company. In the current environment, self-pay patients are much more likely to be asked to pay the list price than insured patients. An example of this is illustrated by the data previously presented in Exhibit 1. This exhibit compares the average list price for an appendectomy in California hospitals in 2002 with the amount actually paid based on the insurance status of the patient. Uninsured patients who do not qualify as indigent (according to each hospital's criteria) pay far more than patients who have insurance coverage.

Hospital list prices will continue to rise faster than costs and net prices, further exacerbating the hardship on the uninsured.

With continuing managed care push back by hospitals, we will see more hospitals terminating their capitated contracts with third party payers. This will move more hospital volume into fee-for-service contracts that generally include list prices in the payment formulae, either in terms of discounts from list price or as part of stop-loss provisions. This will increase the reward to hospitals gained by raising their list prices. Under this scenario, the uninsured will continue to face higher price increases than insured patients.

In some cases, hospitals do discount from list prices for self-pay patients. However, this policy may not be uniformly applied to all self-pay patients within a hospital and discounts vary substantially across hospitals and across the country.

The practice of granting discounts to self-pay patients is ad hoc at best. It varies both across hospitals and within hospitals. As a result, the net price that an uninsured patient pays for hospital care depends not only upon his ability to pay, but also upon his level of education, negotiation skills, where he lives, the hospital he is admitted to, and which if any collection agency is retained by the hospital.

One reason for the wide variation in pricing services for self-pay patients is that hospitals have not really focused on developing an analytical capacity for retail pricing. List prices have grown very quickly and so have only recently become an important element of pricing to hospitals.

Moreover, most hospitals do not have the necessary data systems that allow them to accurately calculate how much they charge or receive from the self-pay population. Self-pay patients often start out in and are billed to a third party payor category and then end up as self-pay. Often the charge is not reclassified while any payments would be credited to the self-pay category. This could understate gross charges to self-pay patients and make it appear that hospitals are collecting a higher percentage of gross charges to self-pay patients than is the case.

Furthermore, the lack of a rational and transparent pricing system for self-pay patients may hinder development and adoption of the health savings account (HSA) reforms.

Individuals choosing an HSA as their primary insurance mechanism may face the same rapidly increasing list prices that the uninsured face since they will be seeking care with their own funds. Moreover, the nascent state of analytical pricing models in hospitals and the absence of management tools that I've already noted could hinder the development and growth of the retail market envisioned under health savings accounts.

Recommendations

1. Form a national Task Force to study current patterns and practices of pricing to the uninsured.
2. Charge the Task Force to:

    a. Develop guidelines for policies and procedures regarding pricing and payment options for the uninsured.
    b. Mandate hospital reporting of both the policies for discounting charges to self-pay patients and the procedures used to ensure that all patients are aware of the discounted payment options.
    c. Mandate that hospitals annually report their actual experience vis-à-vis the uninsured in terms of charges, discounts and collections.

Rationale

Through mandated public disclosure and media attention, social pressure will be brought to bear on hospitals to develop fair and reasonable pricing policies for the uninsured in their communities. As a first step in easing access for the uninsured, hospitals should be required to develop explicit policies and procedures for discounting list prices or charges to self-pay patients. Ideally, the discounting schedule would be a sliding scale based on income.

These policies and procedures should be included in all mailings to patients. When patients receive their first bill, it should clearly state that they may not be required to pay the charge listed. Rather, it should inform them that they are eligible to apply for a reduced fee under the hospitals' discounting program based on specific guidelines.

These policies and procedures should also be posted at the hospital registration area and should be reported to state health departments or other relevant agencies so that the public and media have easy access to this information.

In addition to developing and publicizing policies for charging the uninsured, hospitals should be required to report their experience each year in terms of how the uninsured were billed and the final disposition of their bills. The annual reporting could be incorporated into the recent CMS rule requiring hospitals to report uncompensated care on the Medicare cost report form. Explicit policies and better reporting could serve to moderate the negative and arbitrary effects of rising hospital charges until we have a more systematic solution to covering the uninsured in the United States.

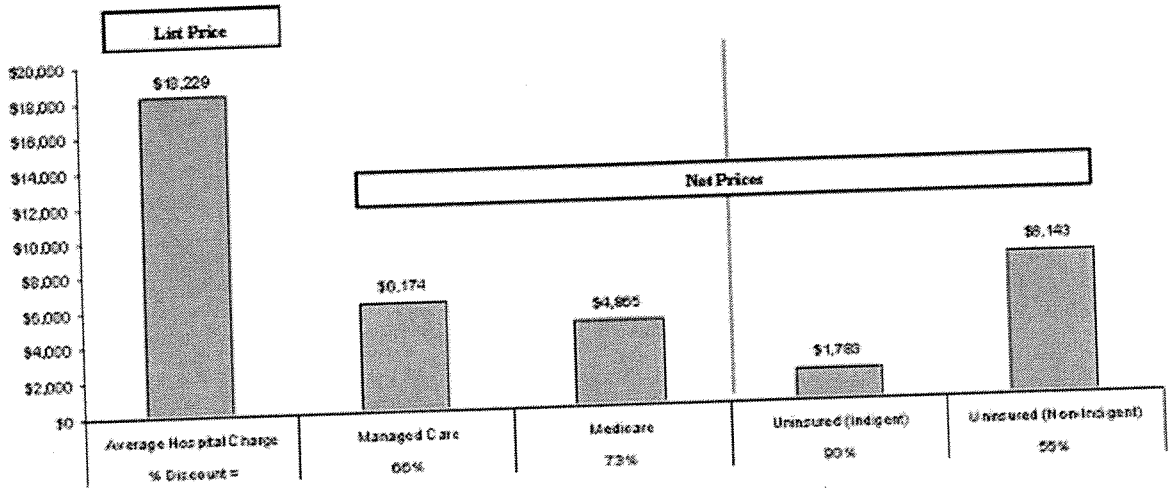
Glenn Melnick

Dr. Melnick is Professor and Blue Cross of California Chair in Health Care Finance at the University of Southern California (USC).

Dr. Melnick has worked extensively in the area of health care insurance and health care market competition. Dr. Melnick's research has focused on the areas of pricing of hospital services, health insurance and health care markets and he has numerous publications in the scientific literature, including journals such as *Health Economics*, *JAMA*, *Health Affairs* and many others. He is frequently called upon to provide expert advice to the Federal Trade Commission, States' Attorneys General and others. His editorials have appeared in the *Wall Street Journal* and the *Los Angeles Times*.

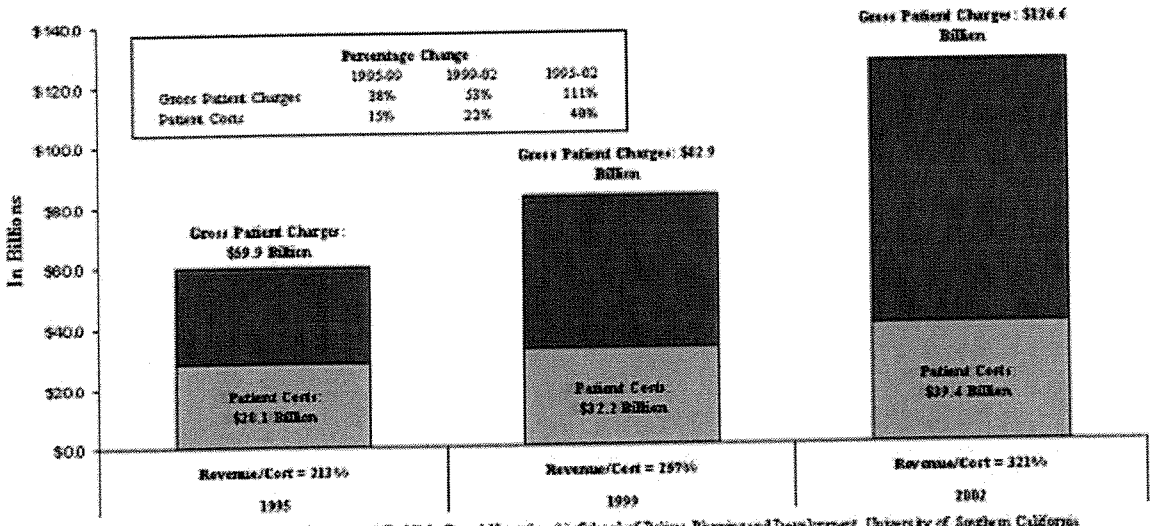
In addition to his work in the US, Professor Melnick works in Pacific Rim countries (including China, Taiwan, and Indonesia) providing technical assistance and training to assist countries in the development of formal health insurance systems and social programs. Dr. Melnick is also the Director of USC's International Public Policy and Management Program (IPPAM). gmelnick@usc.edu

Exhibit 1: List vs. Net Prices for Insured Patients vs. Uninsured Patients: Appendectomy



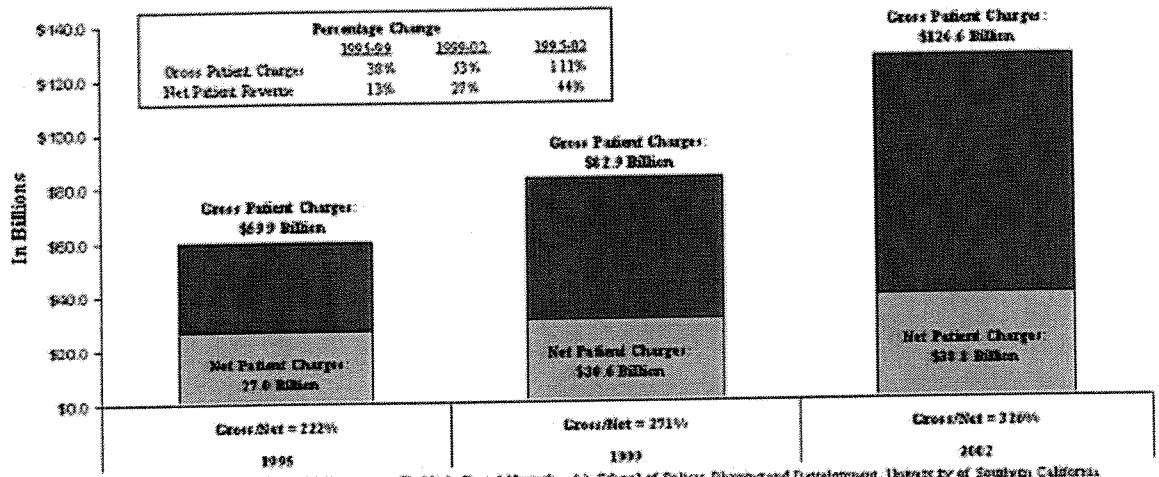
Source: Center for Health Financing, Policy and Management (Reddick, R. and Newaks, A), School of Policy, Planning and Development, University of Southern California
Technical Note: Data are derived from the California Office of Statewide Health Planning and Development, Annual Hospital Discharge File, 2002, Annual Discharge Abstract File, 2002.

Exhibit 2: Trends in Hospital Charges and Costs in California, 1995-2002



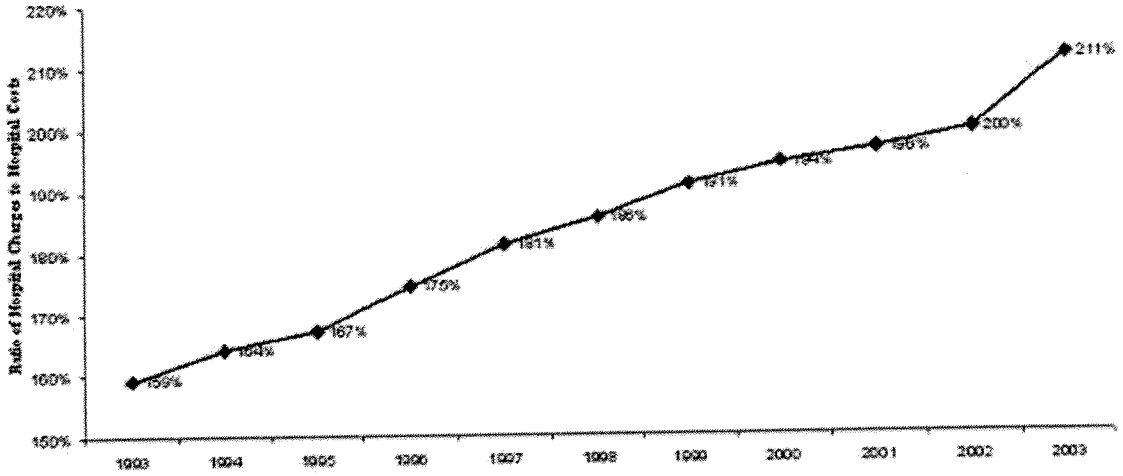
Source: Center for Health Financing, Policy and Management (Reddick, R. and Hurvitz, A), School of Policy, Planning and Development, University of Southern California
Technical Note: Data are derived from the California Office of Statewide Health Planning and Development, Hospital Disclosure File, 1995, 1999, 2002.

Exhibit 3: Trends in Hospital Charges and Revenues in California, 1995-2002



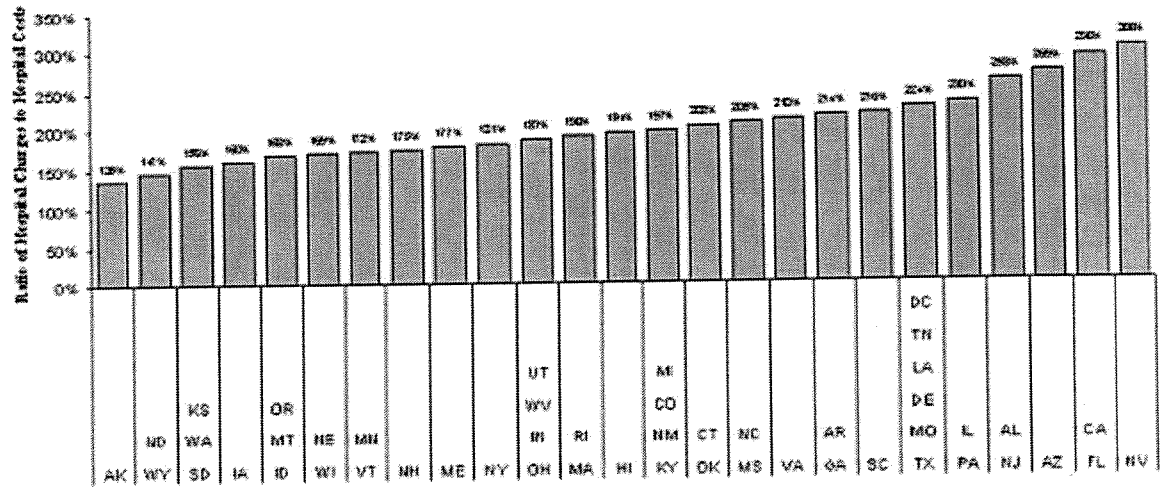
Source: Center for Health Financing, Policy and Management (Reddick, R. and Hurvitz, A), School of Policy, Planning and Development, University of Southern California
Technical Note: Data are derived from the California Office of Statewide Health Planning and Development, Hospital Disclosure File, 1995, 1999, 2002.

Exhibit 4: Ratio of Hospital Charges to Costs in the U.S., 1993 - 2003



Source: Center for Health Financing Policy and Management (Reddick, R. and Horvitz, A), School of Policy, Planning and Development, University of Southern California
Technical Note: Data are derived from the Medicare PPS Impact File, CMS 2003.

Exhibit 5: Ratio of Hospital Charges to Costs by State, 2003



Source: Center for Health Financing Policy and Management (Reddick, R. and Horvitz, A), School of Policy, Planning and Development, University of Southern California
Technical Note: Data are derived from the Medicare PPS Impact File, CMS 2003.